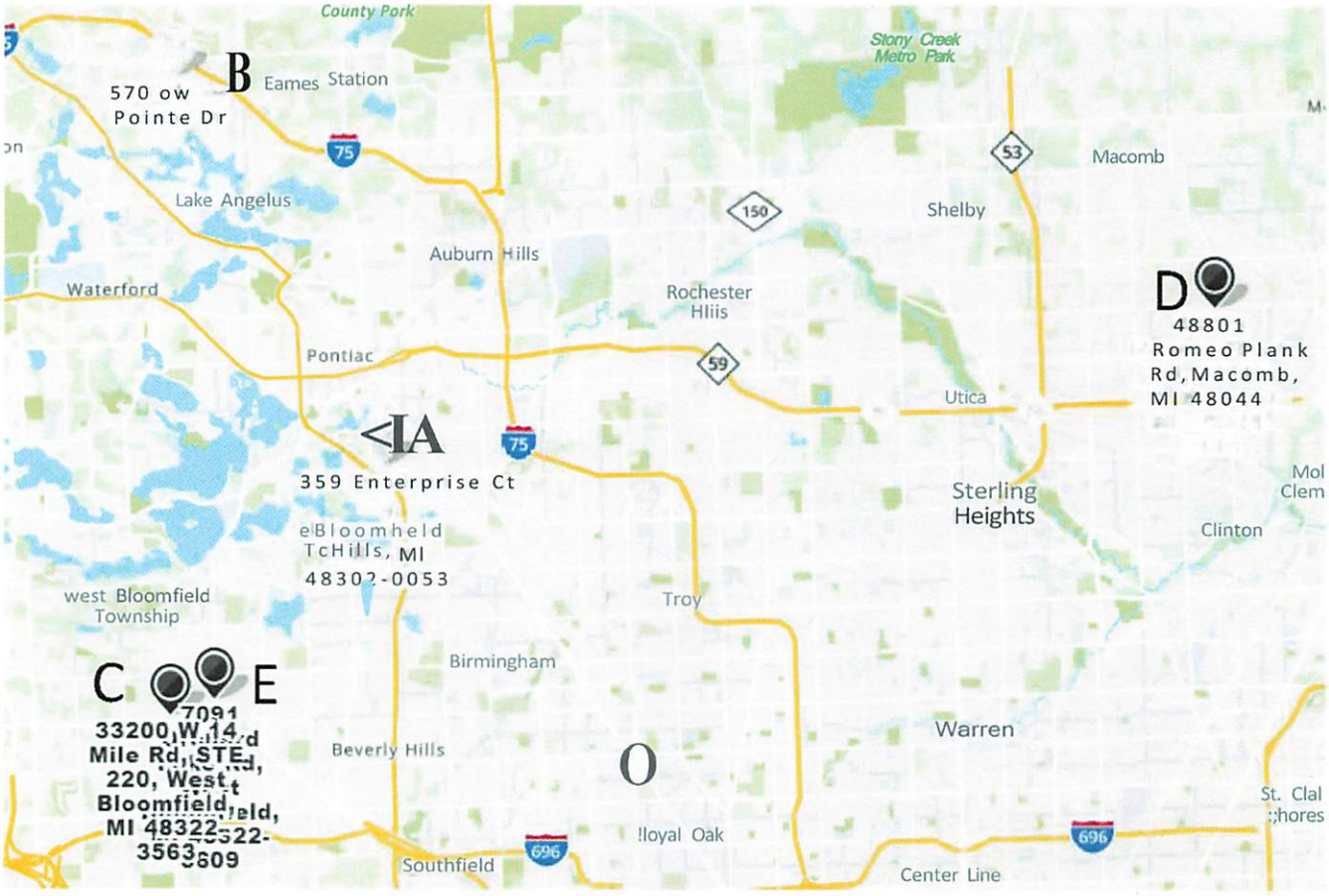
NEUROPAIN
CONSULTANTS



Our Locations:

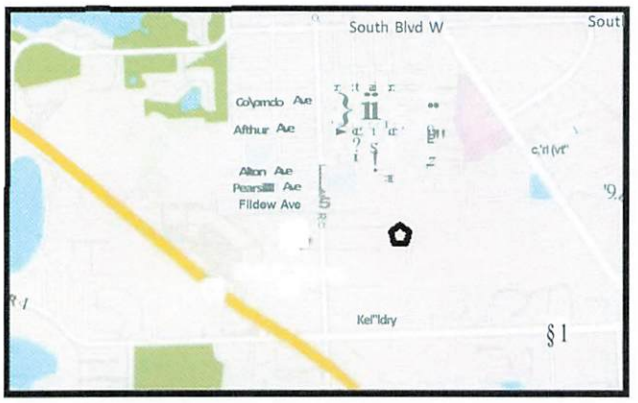
A:359 Enterprise Ct
Bloomfield Hills, MI 48302
Phone (248) 751-7246 **Fax** (248) 418-2311

B: 5701 Bow Pointe Drive Suite 305
Clarkston, MI 48346
Phone (248) 751-7246 **Fax** (248) 418-2311

C: 33200 W. 14 Mile Road Ste. 220
West Bloomfield, MI 48322
Phone (248) 751-7246 **Fax** (248) 418-2311

D: 48801 Romeo Plank
Macomb, MI 48044
Phone (248) 751-7246 **Fax** (248) 418-2311

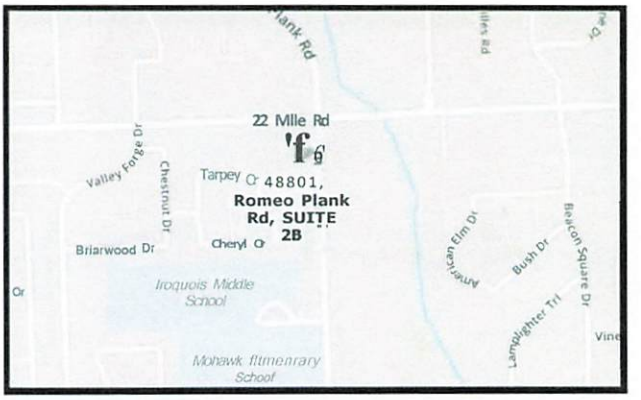
E: 7091 Orchard Lake Rd
Suite 230
West Bloomfield, MI 48322
Phone (248) 751-7246 **Fax** (248) 418-2311



359 Enterprise Court Bloomfield Hills, MI 48302
From 1-75 take exit 75 Square Lake Rd. Continue west app. 3 miles to Franklin Rd. Travel north app. ½mile.Turn right on Enterprise Ct.

5701 Bow Pointe Driver Suite 305 Clarkston, MI 48346
From 1-75 take exit 89. Go south on Sashabaw Rd. app ½ mile to Bow Pointe Dr.

33200 W. 14 Mile Rd Suite 220 West Bloomfield, MI 48322
From 1-696 take exit 5. Go north on Orchard Lake Rd. app. Rd. Left on 2 miles to 14 Mile Rd. Turn left and travel app. 1 mile to destination on right.



48801 Romeo Plank Macomb, MI 48044
From 1-75 take exit 77 to M-59 East. M-59 becomes Hall Romeo Plank.

7091 Orchard Lake Rd Suite 230 West Bloomfield, MI 48322
From 1-696 take exit 5. Go north on Orchard Lake Rd. Approx 2 miles Office will be on the east side.

Neuro Pain Consultants, P.C.

Neurosurgery and Pain Management

www.neuro-pain.com

Welcome

This is a reminder that you have an appointment scheduled with:

Dr._____ On _____ at _____

Please arrive at _____ for a _____ appointment.

☐ Bloomfield – 359 Enterprise Ct, 48302

☐ Clarkston – 5701 Bow Pointe Drive Ste 305, 48346

☐ Macomb – 48801 Romeo Plank Rd, 48044

☐ West Bloomfield – 33200 West 14 Mile Rd Ste 220, 48322

☐ ASC – 7091 Orchard Lake Rd Suite 230 West Bloomfield, MI 48322

*******IMPORTANT*******

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1. Please arrive 30 minutes before your scheduled office appointment or 1 hour without completed paperwork. If you are later than this or your new patient paperwork has not been completed, we may have to reschedule you.
2. **WE MUST HAVE YOUR MEDICAL RECORDS AT FIRST VISIT.** Please request these from your referring physician and bring them with you. We need to have both films and corresponding reports for all diagnostic studies (X-Rays, MRIs, CT scans, Myelogram, EMG) that you have had done.
3. **In order for your physician to give you the best possible care, it will be necessary for you to bring the following items with you to your appointment:**
   A. Driver's License or State ID
   B. Insurance Card(s)
   C. All forms **completed** from the new patient packet
   D. Referral, if you have an HMO. Without one we may not be able to see you
   E. Written authorization letter for workman's compensation or motor vehicle accident claims. Without one we may not be able to see you.

Thank you in advance for your cooperation in providing this information.
If you have any questions, please call (248) 751-7246
Monday-Friday 7:00 AM – 4:45 PM

NPC Patient Information

Basic Information

Full Name _____ ☐ M ☐ F Date of Birth ___/___/____

Driver's License Number _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact _____ Phone Number _____ Relationship _____

Referred by (Physician, Family, Friend, Etc.) _____

Race

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino ☐ Unknown

Primary Language: _____

Employment

Current Status: ☐ Working ☐ Not Working Employer _____

Were you injured at work? ☐ Yes ☐ No Employer Phone _____

Employee Address _____

Insurance

Primary Insurance _____ Contract# _____ Group# _____

Subscribers Name (If other than self) _____ Date of Birth ___/___/____

Secondary Insurance _____ Contract# _____ Group# _____

Auto

Is injury covered by automobile accident insurance? ☐ Yes ☐ No Date of Accident ___/___/____ Claim# _____

Insurance Carrier _____ Carrier Address _____

Name of Insured _____ Adjusters Name _____ Adjusters Phone _____

Adjusters Fax Number _____

Workers Compensation

Is injury covered by Works Compensation? ☐ Yes ☐ No Date of Injury ___/___/____ Claim# _____

Insurance Carrier _____ Carrier Address _____

Adjusters Name _____ Adjusters Phone _____ Adjusters Fax _____

Do you have an attorney for this injury? ☐ Yes ☐ No

Attorney Name _____ Attorney Address _____

What is the name of your Pharmacy? _____ Phone Number _____

Address _____

Neuro Pain Consultants Intake Form

Full Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Intentions for future care: Regenerative Medicine, Medication Management, Interventional (Circle all that apply)

Referring Provider: _____ Primary Provider: _____

What is your current problem? _____

Did anything happen to trigger it? _____

When did it begin? _____

Pain score now? 1-10 _____

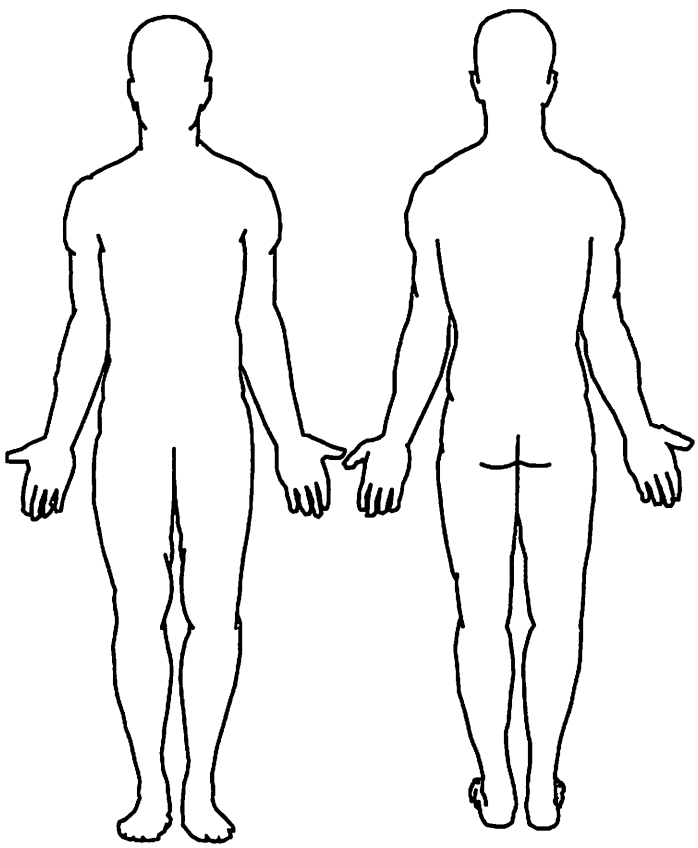
Pain score without medication? 1-10 _____

Pain score with medication? 1-10 _____

Lowest pain score during the last week? 1-10 _____

Highest pain score during the last week? 1-10 _____

Duration of pain? Constant, Constant but variable in intensity, Intermittent, Episodic



Previous Treatment

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ EMG ☐ Bone Scan

☐ Surgery ☐ Epidural ☐ Steroidal Injections ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture

☐ Anti-inflammatory Medications ☐ Non-prescription Drugs

☐ Prescription Medications you have tried and failed? _____

What is the quality of your pain? Aching, Band-like, Burning, Cramping, Crushing, Dull, Heaviness, Electrical, Itching, Numbness, Pulsating, Sharp, Shooting, Stabbing, Stinging, Throbbing, Tightness, Tingling, Vice-like

Associated Symptoms: Weakness, Numbness, Tingling, Erectile Dysfunction, Bladder Incontinence, Bowel Incontinence, Stiffness, Spasms, Loss Of Motor Control, Heaviness, Interference With Sleep, Depression, Anxious

What makes the pain worse?

Any activities, Bending, Carrying, Climbing Stairs, Changing Body Positions, Computer Use, Driving, Exercising/PT, Getting Out of Bed, Going from Sitting to Stand, Lying Down, Lifting, Physical Therapy, Pulling Objects, Pushing Objects, Stress, Sitting, Standing, Twisting, Walking, Weather

What makes the pain better? Acupuncture, Alcohol, Bending, Chiropractor Care, Exercise/PT, Heat, Ice, Massage Therapy, Medication, Sitting, Standing, Stretching, Position Change, Previous Procedures, Lying Down, Walking

Are you currently experiencing any of the following symptoms?

Fever, Chills, Night Sweats, Weight Gain, Weight Loss, Fatigue, Lethargic

Dry Eyes, Eye Irritation, Vision Change

Difficulty Hearing, Ear Pain, Frequent Nosebleeds, Nose/Sinus Problems, Sore Throat, Bleeding Gums, Snoring, Dry Mouth, Mouth Ulcers, Teeth Problems, Mouth Breathing

Chest Pain on Exertion, Arm Pain on Exertion, Shortness of Breath When Walking, Shortness of Breath When Lying Down, Palpitations, Light-Headed When Standing

Cough, Wheezing, Shortness of Breath, Coughing Up Blood, Sleep Apnea

Abdominal Pain, Vomiting, Appetite Change, Black or Tarry Stool, Frequent Diarrhea, Vomiting Blood, Fecal Incontinence, Constipation

Urinary Loss of Control, Difficulty Urinating, Increased Urinating Frequency, Blood in Urine, Incomplete Emptying of Bladder

Muscle Aches, Muscle Weakness, Joint Pain, Back Pain, Swelling in The Extremities

Abnormal Mole, Jaundice, Rash, Itching, Dry Skin, Growths/Lesions

Loss of Consciousness, Weakness, Numbness, Seizures, Dizziness, Frequent or Severe Headaches, Migraines, Restless Legs

Depression, Sleep Disturbance, Restless Sleep, Feeling Unsafe in Relationship, Alcohol Abuse, Suicidal Ideation, Anxiety

Hair Loss, Cold Intolerance, Excessive Bleeding

Runny Nose, Sinus Pressure, Itching, Hives, Frequent Sneezing, Seasonal Allergies

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Are you taking any blood thinners? Yes/No **Are you allergic to any medications?** Yes/No

Medication Allergies: _____

List medications you are currently taking by name, dosage and times a day

Name:	Dose:	Regimen:	Name:	Dose:	Regimen:

Surgical Operations	Year

Past Medical History Please indicate if you have a history of these medical conditions

Anemia	Yes/No	Emphysema	Yes/No	Mental Illness	Yes/No
Anxiety	Yes/No	Glaucoma	Yes/No	Osteoporosis	Yes/No
Arthritis	Yes/No	Heart Disease	Yes/No	Seizures	Yes/No
Asthma	Yes/No	Hepatitis	Yes/No	Spinal Disorder	Yes/No
Blood Clots	Yes/No	High Blood Pressure	Yes/No	Stroke	Yes/No
Cancer	Yes/No	High Cholesterol	Yes/No	Substance Abuse	Yes/No
Chronic pain	Yes/No	HIV	Yes/No	Thyroid Problems	Yes/No
Depression	Yes/No	Kidney Problems	Yes/No	Tumor	Yes/No
Diabetes	Yes/No	Liver Problems	Yes/No	Ulcer	Yes/No

Family Past Medical History Please select all that apply to Father, Mother, Brother, Sister, SoN or Daughter. Unchecked boxes indicate a negative

	F M B S N D		F M B S N D		F M B S N D
Anemia	☐☐☐☐☐☐	Emphysema	☐☐☐☐☐☐	Mental Illness	☐☐☐☐☐☐
Anxiety	☐☐☐☐☐☐	Glaucoma	☐☐☐☐☐☐	Osteoporosis	☐☐☐☐☐☐
Arthritis	☐☐☐☐☐☐	Heart Disease	☐☐☐☐☐☐	Seizures	☐☐☐☐☐☐
Asthma	☐☐☐☐☐☐	Hepatitis	☐☐☐☐☐☐	Spinal Disorder	☐☐☐☐☐☐
Blood Clots	☐☐☐☐☐☐	High Blood Pressure	☐☐☐☐☐☐	Stroke	☐☐☐☐☐☐
Cancer	☐☐☐☐☐☐	High Cholesterol	☐☐☐☐☐☐	Substance Abuse	☐☐☐☐☐☐
Chronic pain	☐☐☐☐☐☐	HIV	☐☐☐☐☐☐	Thyroid Problems	☐☐☐☐☐☐
Depression	☐☐☐☐☐☐	Kidney Problems	☐☐☐☐☐☐	Tumor	☐☐☐☐☐☐
Diabetes	☐☐☐☐☐☐	Liver Problems	☐☐☐☐☐☐	Ulcer	☐☐☐☐☐☐

Social History

What is your marital status? Single Married Divorced Widowed Separated Unknown

Could you be pregnant? Yes No

What is your highest level of education completed?
GED High School Trade School College 2 yr. College 4 yr. Masters

Do you use tobacco? Yes/No If yes, how much _____ **Do you drink alcohol?** Yes/No If yes, how much _____

Are you currently using any of the following?
No Marijuana Cocaine Heroin PCP Other _____

Have you used any of the following in the past?
Never Marijuana Cocaine Heroin PCP Other _____

Are you currently working? Yes Retired Short term disability Long term disability Full-Time/Part-Time Unemployed
Occupation: _____ Employer: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

OSWESTRY- Pain Disability Questionnaire

This questionnaire has been designed to give your Physician/Physical Therapist information as to how your pain has affected your ability to manage in everyday life.

Please answer every section and mark **ONLY** the **ONE** box which best applies to you at this moment.

Section 1 - Pain Intensity

- ☐ I can tolerate the pain that I have without the use of medication.
- ☐ The pain is bad but I manage without taking pain medication.
- ☐ Pain medication gives me complete relief from pain.
- ☐ Pain medication gives me moderate relief from pain.
- ☐ Pain medication gives me very little relief from pain.
- ☐ Pain medication has no effect on pain and I do not use it.

Section 2 - Personal Care (Washing, Dressing, Etc.)

- ☐ I can take care of myself normally with no increase in pain.
- ☐ I can look after myself normally but it does increase pain.
- ☐ It is painful to take care of myself, requiring me to be slower.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of personal care.
- ☐ I do not dress. I wash with difficulty and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights with no increase of pain.
- ☐ I can lift heavy weights but it does increase pain.
- ☐ Pain prevents me from lifting heavy weight off the floor but I can manage if conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weight off the floor but I can manage light - medium ones conveniently positioned, ie. on a table.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- ☐ I can sit on any chair as long as I want.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 - Standing

- ☐ I can stand as long as I like without increasing my pain.
- ☐ I can stand as long as I like but it increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only using medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8 - Sex Life

- ☐ My sex life is normal and causes no increase in pain.
- ☐ My sex life is normal but causes some pain increase.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by my pain.
- ☐ My sex life is nearly absent because of my pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social Life

- ☐ My social life is normal and causes no pain increase.
- ☐ My social life is normal and causes some increase in pain.
- ☐ My pain has no effect on my social life apart from limiting more energetic interests such as dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of my pain.

Section 10 - Traveling

- ☐ I can travel anywhere with out increasing my pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain is bad but I manage trips over 2 hours.
- ☐ My pain restricts journeys to less than 1 hour.
- ☐ My pain restricts me to short necessary trips less than 30 min.
- ☐ My pain prevents me from travel except for medical appointments and the hospital.

PCS-EN Questionnaire

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 - Not at all 1- To a slight degree 2 - To a moderate degree 3 - To a great degree 4 - All the time

When I'm in pain...

- ☐ I worry all the time about whether the pain will end.
- ☐ I feel I can't go on.
- ☐ It's terrible and I think it's never going to get any better.
- ☐ It's awful and I feel that it overwhelms me.
- ☐ I feel I can't stand it anymore.
- ☐ I become afraid that the pain will get worse.
- ☐ I keep thinking of other painful events.
- ☐ I anxiously want the pain to go away.
- ☐ I can't seem to keep it out of my mind.
- ☐ I keep thinking about how much it hurts.
- ☐ I keep thinking about how badly I want the pain to stop.
- ☐ There's nothing I can do to reduce the intensity of the pain.
- ☐ I wonder whether something serious may happen.